State of Kansas **Comparison of State Employee Plan with Maine's Dirigo Plan**

Plan Benefit	Dirigo (PPO) In-Network	KS SEHP 2004 PPO In-Network
Deductible		
Individual	$1,250 (INN and OON combined)	n/a
Family	$2,500 (INN and OON combined)	n/a
Out-of-Pocket Maximum (Includes deductible)		
Individual	$4,000	$2,200
Family	$8,000	$4,400
Coinsurance	80% / 20%	50%/50% (Tiered Coins after $1100/$2200 = 30%)
Lifetime Maximum	Unlimited	$2,000,000
Emergency Room Care	Subject to deductible and coinsurance	$100 copayment (waived if admitted) then coinsurance.
Hospital Services		
Inpatient	Subject to deductible and coinsurance	$300 copay per admit then coinsurance
Outpatient	Subject to deductible and coinsurance	Subject to coinsurance
Physician Office Services		
PCP Office Visit	**$15 copayment** Included but not limited to: Sick Care, Family Planning, Diagnostic Testing, Allergy Testing and Injections.	Subject to coinsurance
Specialist Office Visit	$25 copayment	Subject to coinsurance
Preventive Care	**100%** Included but not limited to: Office Visit, Immunizations, Well Child Care, Standard Screening tests performed as a part of the physical exam, Lab/X-Rays associated with Preventive visits.	1st $300 covered in full, then coinsurance
Physician Hospital Visits	100%	Subject to coinsurance
Surgery & Asst. Surgeon Fees	100%	Subject to coinsurance
Laboratory/X-Ray	Subject to deductible and coinsurance. Unless ordered as part of a routine physical, then it is covered at 100%	Subject to coinsurance
Mammography	100%	Applies towards preventive care allowance, then coinsurance
Pap Smear		
Routine Preventive Test		

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Prescription Drug – Retail Program (30 day supply)		
Generic	$10	20% coinsurance, subject to $2580 Max Drug Coinsurance
Preferred Brand	$25	35% coinsurance, subject to $2580 Max Drug Coinsurance
Non-Preferred Brand	$40	60% coinsurance, no max
Prescription Drug - Mail Order Program (90 day supply, Oral contraceptives are covered)		
Generic	$30	No difference indicated from Retail
Preferred Brand	$75	
Non-preferred Brand	$120	
Maternity Expenses		
Pre/Post Natal Office Visits	100% after $25 copayment	Subject to coinsurance
Delivery Charges	Subject to deductible and coinsurance	Subject to $300 copay, then coinsurance
Newborn Hospital Bill	Subject to deductible and coinsurance	Subject to coinsurance
Newborn Pediatrician	100%	Applies towards preventive care allowance, then coinsurance
Rehabilitation Therapies	Rehabilitation Therapies are covered up to a combined limit both in and out of network of $3,000 per calendar year.	Subject to prior approval. Outpatient is limited to 180 consecutive days, with documented approval
Physical Therapy Occupational Therapy Cardiac Rehabilitation Speech Therapy	Subject to deductible and coinsurance	Subject to coinsurance
Home Health Care	Subject to deductible and coinsurance	Subject to coinsurance, limit of $5000 per year
Skilled Nursing Facility	Subject to deductible and coinsurance 100 days per calendar year combined in- and out-of-network.	Not listed specifically, subject to coinsurance
Hospice Care	100%	Subject to coinsurance, lifetime limit of $7500
Mental Health Care		
Inpatient (Non-listed illnesses)	Coin after $150 Mental Health deductible is met Maximum of 30 days per calendar year	Inpatient Copay, then coinsurance. 60 limit per year
Outpatient (Non-listed illnesses)	Coin after $150 Mental Health deductible is met Maximum of $1,500 per calendar year	First 3 visits 100%, next 22 have $25 copay. Additional visits 50% coinsurance.

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Substance Abuse		
Inpatient	Coin after $150 Substance Abuse deductible is met Maximum of 31 days per calendar year Two days of day treatment equal one day of inpatient services.	Same as Mental Health
Outpatient	Coin after $150 Substance Abuse deductible is met Maximum of $1,500 per calendar year	Same as Mental Health
Ambulance	Subject to deductible and coinsurance	Subject to coinsurance
Acute Chiropractic Treatment	Ded/Coin 40 visits per calendar year	Not covered
Allergy Care	Subject to deductible and coinsurance	Subject to coinsurance
Allergy Injections	Subject to deductible and coinsurance	Subject to coinsurance
Durable Medical Equipment (DME)	Subject to deductible and coinsurance Limited to $3,500 / calendar year	Subject to coinsurance, limit of $4500 per year
Prosthetic Appliances and Orthotics	Subject to deductible and coinsurance	Not covered
Smoking Cessation	100%	Not covered
Chemotherapy and Radiation Therapy	Subject to deductible and coinsurance	Subject to coinsurance
Second Surgical Opinions	Office visit with specialist $25 copayment	Not listed specifically, subject to coinsurance
Refractive Eye Exam one every 2 years	100% after $25 copay	Applies towards preventive care allowance, then coinsurance
Lenses, Frames, and Contacts Lenses	Not Covered	Not covered
Refractive Vision Surgery	Not Covered	Not covered
Elective Abortion	Subject to deductible and coinsurance	Not listed specifically, subject to coinsurance??
Artificial Insemination	Not Covered	Limited to testing & 3 attempts at artificial insemination per year. Subject to coinsurance.
IVF GIFT ZIFT	Not Covered	
Fertility Medication	Not Covered	
Surgical Treatment of Underlying Medical Condition Causing Infertility	Not Covered	
Reversals of sterilization	Subject to deductible and coinsurance. Vasectomies and tubal ligations are only covered under the plan in network only and only once per lifetime.	
Dental Services	**Not listed as covered**	Provided by Delta Dental